

Welcome to Belk Eye Clinic

Name: Ms. Mrs. Mr. Dr. _____ Today's Date: ____ / ____ / ____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone: _____

Marital Status: _____ Cell Phone: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Place of Employment: _____

Name of Medical Doctor: _____ Occupation: _____

Dr.'s Phone: _____ Last Medical Exam: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

How did you learn about our office? _____ Your E-mail Address: _____

Insurance Information

Guardian (If Applicable): _____

Primary Insurance: _____ Member ID#: _____

Name of Policyholder: _____ DOB: _____

Secondary Insurance: _____ Member ID #: _____

Name of Policy Holder: _____ DOB: _____

Vision Insurance: _____ Member ID #: _____

Name of Policyholder: _____ DOB: _____

Ocular History Main reason for your appointment today? _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and / or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

** Please turn this form over and complete side two **